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WORLDWIDE REPORT
EPIDEMIOLOGY

CONTENTS

BANGLADESH

PEOPLE NEED INSTRUCTION IN FIGHTING TUBERCULOSIS

Dhaka THE NEW NATION in English 12 Mar 86 p 5

[Editorial: "... of Tuberculosis"]

[Text] Tuberculosis still remains one of the most dreaded diseases in countries like Bangladesh where lack of proper treatment facility coupled with shortage of proteinous food always raises the chance of fatality to a proportion much higher than it necessarily should have been in a different situation. The spread of this curable disease cannot be effectively resisted also because of the total absence of a testing system to find out patients at a very early stage of the disease. The common people, on the other hand, are yet to be fully aware of the danger they live with; and they do not see a doctor unless the disease has considerably aggravated. This was confirmed by a report published in a leading Bangla daily on Monday last. Referring to statistics the report says that the germ of tuberculosis is found in 40 percent of the people of Bakergonj Upazila and in eight other upazilas of the district the figure is 19 percent.

This shocking revelation comes at a time when the world on the one hand, aims to bring health for all by the year 2000, and on the other, the UNICEF has just cut its programme of financing the campaign against the disease treatment. In this situation one can only imagine the treatment facilities and food the patient will enjoy at different tuberculosis clinics and hospitals in future.

A massive programme like eradicating the disease from the country cannot be carried out without the help from international bodies such as WHO or UNICEF. Given this condition, we would like to remind the authority concerned that a true picture of the disease published in time may persuade those international agencies to consider again that after all tuberculosis continues to be a menace to mankind and there was no need to call off the fight against it.

However, alongside this we have to pull as much of our internal resources as possible because the way the disease is spreading points to the need of waging war on it at home first. If we cannot provide proper treatment to the diseased, we can at least let them know how they must not infect people coming into their close contact. And this certainly is one of the best ways of combating this disease.

/12851
CSO: 5450/0128

BELIZE

BROAD GOVERNMENT IMMUNIZATION PROGRAM UNDER WAY

District Campaigns

Belize City THE REPORTER in English 9 Mar 86 p 10

[Excerpt] Starting next Tuesday, March 11 the Ministry of Health will begin an ambitious week-long campaign in Corozal to reach all young children of the district to immunize them against Polio, Measels, Diptheria, Whooping Cough and Tetanus.

The campaign calls for each child to receive three doses of Pilio vaccine. At this time they will also be vaccinated against Measels. Children who have not been vaccinated against Diptheria, Whooping Cough and Tetanus will also get protection against these. The vaccines against Polio and Measels will be administered to each child, whether that child has had previous protection or not.

Children who have been vaccinated against Diptheria, Tetanus, etc. will not need to have these again if they can show proof of that they have been protected.

The Ministry of Health has organized a task force to carry out the massive vaccination campaign, which will begin in Corozal at 8 a.m. The Ministry has set itself a target of reaching 90 percent of all the children.

[In its 23 March issue, THE REPORTER announces Ministry of Health plans for the Stann Creek District: "During the first week of April the Ministry of Health will be continuing its campaign to protect babies and small children from Polio and Measles, Whooping Cough, Tetanus and Diptheria in the Stann Creek District. All babies three months and older and all children under the age of five are expected to get this protection. Parents and guardians are required to take their children to be immunized."

[On 6 April, page 4, the paper reports on the program for the Toledo District slated for the second week of April.]

Plea for Sanitation

Belize City THE REPORTER in English 6 Apr 86 p 2

[Editorial]

[Text]

PUBLIC RESPONSE to the country-wide immunization campaign to protect babies and young children against Measles, Whooping Cough, Tetanus, Diphtheria and Poliomylitis has been good beyond expectations.

During two weeks of March and the first week of April immunization health teams have combed through three districts, visiting 152 communities including such nooks and crannies as Arenal, Plantain Sucker, Young Gal, Ring Tail and Sarawee. Next week the teams will be going south, to the Toledo District, where there are 37 remote communities, some of them approachable only by water.

There is evidence that the Government, with help from UNICEF, proposes to do a lot more. Under an agreement signed in San Salvador last week by Health Minister Aragon, Belize will participate in a Central American putch involving an overall budget of $30 million over a five year period. The plan calls for better controls over sanitation and the causes of diarrhoea and respiratory infections, immunization and good eating and living habits.

This is a good programme and badly needed. But it could be greatly enhanced if we, the people of Belize, were to do something about sanitation in the old capital.

People still throw their garbage and unwanted stuff in the streets, in the drains and in the canals without a twinge of conscience. Periodic clean-up campaigns organized by the City Council and other civic bodies have done nothing to change living habits. Rats and roaches and house flies abound in an environment where one untidy yard is sufficient to contaminate a whole block.

It is going to be difficult to get all people of Belize City to clean up their yards, especially in those areas where many buildings occupy a single, unfenced area. But it should be possible for us to make immediate headway in the clean-up of our streets, our drains and canals.

The canals are essential for drainage. They can be covered up, or better still, replaced with large culverts, but only at a high cost. In the meanwhile, we have to live with open canals as part of the price we pay for clinging to Belize City.

We need strong health laws and strict enforcement if we are to keep the canals and drains that empty into them clean. This is not going to be a popular task, but it is essential for better health. All of us recognize this one fact.

We believe that there is simply too much political pressure on the Belize City Council to allow it to carry out a strict enforcement policy. So maybe we need a Statutory Health Authority, charged with the important mission of enforcing the Health and Sanitation laws and keeping these important waterways clean and free-flowing. It might take ten years, but once Belizeans understand that the Health Laws are binding on each individual, we will see a marked improvement in how our city looks and behaves.

/9274
CSO: 5440/069

CANADA

AIDS TEST, COUNTERMEASURES, INCIDENCE DISCUSSED

New Quebec Test

Ottawa THE CITIZEN in English 7 Apr 86 p A3

[Text]

TORONTO (CP) — A new test to determine whether people are likely to develop AIDS is faster, cheaper, more accurate and easier to administer than other methods, says the institute that created it.

Medical researchers and government experts also describe the test, called immunofluorescence assay, as a major advance in the quick and cost-effective detection of anti-bodies to the HTLV-III virus, which causes acquired immunodeficiency syndrome.

It was developed at the Institut Armand Frapper, a research and manufacturing centre outside Montreal, by Dr. Jean-Marie Dupuy, director of the immunology department. The centre is expected to announce that the test is commercially available this week.

The test, which determines if a person has antibodies to the virus in his or her blood, has two important advantages, the institute says. Patients showing symptoms of the disease can be diagnosed and treated more quickly if they are infected — and reassured if they are not.

It will also make Canada's blood supply safer, experts say. Since the test is more accurate than current methods, it will more effectively screen out infected blood offered by donation.

The test, which will cost $8 a patient, gives researchers easily understood visible confirmation: a slide of the patient's blood cells will glow bright green in areas that have been exposed to the HTLV-III virus.

The cost compares to $130 a patient for a Western blot, the "gold standard" considered essential to confirm initial screening tests.

The new test can be used in virtually any laboratory and gives results within hours, the institute says.

The research centre considers the test sufficiently accurate, particularly in cases of patients in high-risk groups such as hemophiliacs, homosexuals and intravenous drug users, that it can supplant use of one or both of the two current methods, the Elisa test and Western blot.

Dupuy estimated the Canadian market for the new product is 50,000 to 200,000 tests annually. In the United States, it is as many as 500,000 a year.

Dupuy said the institute is negotiating with a major U.S. manufacturer about the possibility of entering the American market.

Research Fund Raising Committee

Toronto THE GLOBE AND MAIL in English 8 Apr 86 p A5

[Text]

MONTREAL

A committee of medical researchers from across the country was established yesterday to find financing for AIDS research. "There is very little money and there are no big commitments from the federal and provincial governments," said Michel Roy, president of the Foundation for Research for Immuno-Deficiency Syndrome Quebec Inc. "That's why we have to go ahead with fund-raising." Mr. Roy, a television commercial producer, said the group wants to raise $1-million in the next year to establish a clinic to study the deadly virus. So far, there have been 529 reported cases and 257 of the victims have died. No cure is known and most AIDS patients die within two years of diagnosis. AIDS is transmitted through sexual contact and contaminated blood.

Slowing Growth Rate

Toronto THE TORONTO STAR in English 9 Apr 86 p A18

[Text]

OTTAWA (CP) — Precautions taken by male homosexuals appear to be working, as the growth rate of AIDS in Canada slows, federal health officials say.

But now they are starting to worry about the potential for bisexual males and female prostitutes spreading the deadly virus of acquired immune deficiency syndrome.

The number of cases of AIDS now is doubling every 11 or 12 months rather than every 6 months, says Dr. Alastair Clayton, head of the federal government's Laboratory Centre for Disease Control and a member of the national advisory committee on AIDS.

Similar trends have been noted in the United States, Clayton said in an interview yesterday. The number of cases of AIDS in the large homosexual population of San Francisco appears to be reaching a plateau.

"So there are early indications that in the male homosexual society, preventive measures, lifestyle modifications, are taking effect," Clayton said. "It's very encouraging."

He said male homosexuals have become more discriminating in their choice of sexual partners and are more apt to use condoms to reduce the chance of spreading AIDS.

The concern now is finding ways to promote the same kind of preventive measures among male bisexuals and female prostitutes.

Bisexual males could have normal heterosexual family lives at home and engage in indiscriminate homosexual liaisons on the road, Clayton said. This makes it unlikely that they would publicize their sexual habits or be active members of homosexuals' organizations that have been in touch with experts on AIDS.

AIDS is a condition caused by a virus that destroys the body's natural ability to fight infection.

Admission of Overestimation

Ottawa THE WEEKEND CITIZEN in English 5 Apr 86 p A3

[Text]

TORONTO (CP) — Health and Welfare Canada has overestimated the number of Canadians who will develop AIDS by as much as 10 times, a leading Canadian statistician says.

Dr. Alastair Clayton, director general of Health and Welfare Canada's Laboratory Centre for Disease Control, said last September that if current trends continued, more than 20,000 Canadians would contract AIDS by 1990. No cure or vaccine has been discovered for the viral disease, which destroys the ability of the body's immune system to fight off disease.

However, Dr. Ian MacNeill, an internationally recognized statistician from the University of Western Ontario, estimates that slightly more than 2,000 Canadians — one-tenth of the government's estimate — will develop AIDS by the end of the decade.

Federal health officials acknowledge they have known their estimates were wrong for about five months. But neither they nor spokesmen for Health Minister Jake Epp, who is out of the country, could explain Friday why the public has not been informed that the AIDS picture is not as bleak as first portrayed.

The government is expected to release a more accurate estimate of cases in Canada of acquired immunodeficiency syndrome within a week or two.

Using Health and Welfare data, MacNeill said the rate at which new AIDS cases are being reported is already starting to slow down and may be reaching a plateau.

"The LCDC forecasts are breathtaking," said MacNeill, an expert in time-series analysis and forecasts.

Clayton said in an interview Friday that his first estimates of more than 20,000 AIDS cases by 1990 and a later estimate of 14,000 "were very, very crude." He added that "no one should take them seriously."

Manitoba Cases

Toronto THE GLOBE AND MAIL in English 3 Apr 86 p A4

[Text]

WINNIPEG

Three Manitoba men have been confirmed as having AIDS and at least 14 more people in the province have been exposed to the deadly virus, a spokesman for the Sexually Transmitted Disease Control Section says. Pat Matusko said the latest confirmations mean a total of four Manitobans have contracted acquired immune deficiency syndrome since it was discovered in the province nine months ago. One of the victims died on Dec. 20. More than 100 people in the province have had themselves tested for the AIDS antibody since December. Of these, 14, including men, women and children, have tested positively. A positive test does not necessarily mean a person has AIDS.

Education Grant Needed

Toronto THE TORONTO STAR in English 9 Apr 86 p A6

[Text]

The Aids Committee of Toronto is asking for a $65,000 emergency grant from the city to help the organization continue its education campaign and move into larger offices.

Of the 143 cases of acquired immune deficiency syndrome reported in Metro, the majority came from the City of Toronto, the committee's spokesman, Joan Anderson, told the city's health board yesterday.

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CSO: 5420/65

CANADA

DIARRHEA OUTBREAK HITS 37 AT LONDON CHRONIC CARE HOSPITAL

Toronto THE TORONTO STAR in English 7 Apr 86 p A2

[Article by Paula Adamick]

[Text]

LONDON, Ont. — An outbreak of diarrhea has struck 37 patients and staff at a London chronic care hospital in the past few days, London's medical health officer said yesterday.

Twenty-four of 59 patients at Grace Villa Hospital in downtown London have been hit with what appears to be stomach flu, said Dr. Doug Pudden, but none are seriously ill.

Thirteen staff members have also been affected by the diarrhea outbreak.

"The outbreak has slowed down considerably and most of those affected are quite well," Pudden said. "There are really no seriously ill patients."

Isolation units have been set up at the hospital and visitors are being discouraged from coming, Pudden said.

Patients will not be discharged until the illness has run its course.

Pudden said that although the cause of the disease has not been pinpointed, he thinks it was most likely caused by a virus passed by personal contact.

The 59 patients at the 60-bed private hospital are between the ages of 65 and over 100.

The outbreak is the second to hit the city in the past week. Extendicare London was hit by an outbreak of gastrointestinal flu that affected four residents on Good Friday, sending one to hospital. That outbreak was declared over early last week.

Last fall, Extendicare London was hit by a deadly bacterial outbreak which killed 19 residents.

/9317
CSO: 5420/66

CANADA

DIPHTHERIA DIAGNOSED IN SOUTHEAST ASIAN CHILD IN OTTAWA

Ottawa THE CITIZEN in English 4 Apr 86 p A13

[Text]

About 150 students and teachers at two Ottawa schools were given booster shots for diphtheria last fall after a child was diagnosed as having the disease and three siblings were found to be carriers.

Associate Medical Officer of Health Ian Gemmill said the precaution was taken last November after the child was diagnosed at the Children's Hospital of Eastern Ontario.

Diphtheria is a respiratory illness involving bacteria that can produce a poison toxic to heart muscles, resulting in some cases in cardiac problems or death.

The patient is also at risk of being suffocated if a membrane that sometimes forms in the back of the throat becomes detached and blocks the airway.

The disease, which can be passed on by coughing, has occurred rarely in Canada as a result of a vaccine that was developed about 1930.

In 1924, the first year Canadian health officials began keeping statistics on the disease, there was an all-time high of 9,000 cases.

Since 1981, there have never been more than 11 cases.

Gemmill said the child diagnosed last fall had come to Canada from southeast Asia with her mother and two siblings in October 1985. The father and two other children had been in Canada for several years.

All the children were attending school, one at junior high school and the other four at an Ottawa elementary school.

As a result of the diagnosis at CHEO, the family was quarantined for about seven days and given the standard antibiotic treatment for diphtheria, Gemmill said. Three of the other children were found to be carriers of the disease.

The health unit notified parents of children who shared classes with members of the family and gave them booster doses of the diphtheria vaccine. Any child in the schools whose diphtheria immunization was not up-to-date was also given a booster.

In all, about 150 people received the booster shots, he said.

Tests of all the children who shared classes with members of the family turned up no positive results for diphtheria, Gemmill said.

Gemmill said the Ottawa incident shows that cases of diphtheria can still be imported.

"It's not an impossible thing to happen because many developing countries don't have immunization programs as complete as they are here."

The experience emphasizes the need for people to keep their immunization status up to date, he said.

Vaccination and booster shots for diphtheria are given periodically after age two months. Subsequent protective shots are given at age four months, six months, 18 months and five years.

After that, boosters should be had every 10 years.

/9317
CSO: 5420/66

CANADA

POST-POLIO SYNDROME APPEARS 30 YEARS LATER

Vancouver THE SUN in English 27 Mar 86 p B1

[Text]

TORONTO — More than 30 years after thousands of Canadians were stricken with polio during a North American epidemic, a large number of survivors are experiencing what appears to be a recurrence of symptoms.

The affected survivors — most of whom were children or teenagers during the 1950s outbreak of polio or infantile paralysis — are complaining of a renewed weakening of muscles, fatigue, morning headaches and serious lung problems after years of being symptom-free, says Dr. Roger Goldstein, director of respiratory medicine at West Park Hospital in Toronto.

"Over the last few years, some patients who had polio are showing new symptoms, with a reduction in strength and endurance of affected muscles and unaffected muscles," he told about 200 health-care workers attending a Lung Association seminar Wednesday.

The "post polio syndrome" appears to have affected about 20 per cent of survivors, said Goldstein, but there is no evidence the muscle-weakening and other symptoms are caused by a resurgence of a latent form of the polio virus in the body.

More than likely, they are caused by a combination of the natural aging process and overworking of muscles already debilitated by the disease, he said.

Polio survivors at risk of developing fresh symptoms are those who contracted the crippling viral disease after age five, spent time on an artificial breathing apparatus, suffered paralysis and underwent years of rigorous rehabilitation.

/9317
CSO: 5420/66

CANADA

DENTAL HEALTH PROMOTION CAMPAIGN AIMED AT ELDERLY

Toronto THE TORONTO STAR in English 9 Apr 86 p A6

[Article by Laurie Monsebraaten]

[Text]

Toronto is set to become the first city in North America to launch a dental health promotion campaign for seniors living on their own.

The multi-media promotion and education blitz slated for the last week of June is just part of what Toronto health officials are calling "a major commitment by the city to improve dental health among its 68,000 elderly."

The campaign, unveiled at the city's health board yesterday, will cost the city about $20,000. The Canadian Dental Association is expected to contribute an additional $30,000 to $60,000 to the effort.

"More than half of the seniors living in the community haven't been to the dentist in the last five years," said Jack Lee, the city's dental adviser.

"The message we want them to get is that just because you're 60, it doesn't mean you should lose teeth."

The Toronto Mayor's Committee on Aging was "delighted" with the scheme.

"For my generation and those that came before me, dental care was not a priority," said committee member Amy Thompson.

A city-run dental referral service will help seniors get affordable care, Lee said.

In addition to the week-long dental health promotion, the board approved a daily oral hygiene plan for seniors living in nursing homes, homes for the aged and chronic care hospitals.

A complete geriatric dental program should include education, regular checkups, two annual oral hygiene sessions, denture identification and cleaning and referrals for treatment if necessary.

This program would cost about $150,000 a year, he said.

/9317
CSO: 5420/66

CANADA

SEVEN HEALTH-CARE PROFESSIONS TO GAIN LEGAL STATUS

Ottawa THE CITIZEN in English 4 Apr 86 p A5

[Text]

TORONTO (CP) — Seven health care professions, including midwifery, will receive legal status for the first time under a regulatory system proposed Thursday by Health Minister Murray Elston.

The new system, which will replace legislation on the books in some cases since the 1920s, will see 25 health care professions ranging from doctors and dentists to laboratory technologists and midwives — regulated by the Health Ministry.

By obtaining legal status for the first time, the seven professions will be allowed to set up their own self-regulating body, establish standards and license members, making it easier to protect consumers from poor practitioners.

The seven newly-regulated professions are audiologists, dieticians, medical lab technologists, occupational therapists, respiratory technologists, speech-language pathologists and midwives.

While it's not technically illegal to practise midwifery, midwives are not recognized by provincial law nor are there facilities to train them.

/9317
CSO: 5420/66

CANADA

BRIEFS

VACCINES FOR BRAZIL--Connaught Laboratories Ltd of Toronto has a contract from the Government of Brazil to supply 28 million doses of DPT (diphtheria/pertussis/tetanus) vaccine and 15 million doses of TT (tetanus toxoid) this year. The quantities are expected to be sufficient to immunize all Brazilian children against these three major diseases. The contract brings to more than 63 million the number of vaccines doses ordered this year from Connaught by various Latin American companies. [Text] [Toronto THE GLOBE AND MAIL in English 10 Apr 86 p B2] /9317

CSO: 5420/66

BRIEFS

AIDS SPENDING--About $4.5 million has been spent on the treatment and prevention of AIDS during the past eight months. This was disclosed yesterday by the Director of Medical and Health, Dr K. L. Thong. An extra $1,896,000 will be allocated to finance the Acquired Immune Deficiency Syndrome (AIDS) virus screening programme for donated blood run by the Hongkong Red Cross Blood Transfusion Service for 1985-86. The request for supplementary provision was approved by the Finance Committee yesterday. Last month, the committee approved a provision of $25,221,000 for the AIDS virus screening programme. But the Red Cross Blood Transfusion Service now estimates that total expenditure will amount to $27,117,000 taking into account the revised cost of blood collection and distribution services, and the latest cost of the screening programme. [Excerpts] [Hong Kong SOUTH CHINA MORNING POST in English 8 Mar 86 p 10 & 13 Mar 86 p 14] /12851

POLIO IMMUNIZATION--Polio, a disease which kills up to 50,000 children worldwide each year, may be eradicated by the 1990s, announced Rotary International at a press conference yesterday. Rotary International started a programme in Hongkong to promote and assist polio immunisation of children last year. At first, they set a target date of 2005 for immunising children worldwide, but with the tremendous success achieved, the date has been put forward. A district governor of Rotary International, Mr Nuno Jorge, said the organisation first started the project in the Philippines. Its success there prompted the group to extend the programme to all countries that need help. Polio is well under control in advanced countries but it still poses a threat in developing countries. According to statistics, some 75 million children worldwide are not protected against polio. The disease kills up to 50,000 children each year. At least one child out of every 200 born in the developing world is doomed to be crippled by polio. [Text] [Hong Kong SOUTH CHINA MORNING POST in English 20 Mar 86 p 5] /12851

DECLINE IN TB--The number of tuberculosis cases in Hongkong has continued to decline over the past year, according to the Director of Medical and Health Department, Dr K. L. Thong. Speaking at the Annual General Meeting of the Hongkong Tuberculosis, Chest and Heart Diseases Association, Dr Thong -- who is the president -- said new notifications of tuberculosis dropped to 7,545 in 1985 from 7,843 the previous year. The notification rate had declined correspondingly from 146.2 to 139.1 per 100,000 people. Deaths from

tuberculosis also continued to fall -- from 420 in 1984 to 409 in 1985. The death rate dropped from 7.8 to 7.5 per 100,000 people. He said 184 cases of silicosis -- a lung disease due to inhalation of silica -- were reported in 1985 boosting the total number of cases reported to 2,801. [Excerpts] [Hong Kong SOUTH CHINA MORNING POST in English 25 Mar 86 p 2] /12851

CSO: 5440/071

KENYA

BRIEFS

ANTI-AIDS CAMPAIGN INITIATED--The Ministry of Health has organised a series of workshops for its personnel who will be used in a campaign to create awareness on the Acquired Immunity Deficiency Syndrome (AIDS). And the first of such workshops was held in Embu for health personnel from Eastern province. Addressing the participants, the chief nursing officer, Mrs E.N. Ngugi, said her ministry recognised that AIDS and AIDS virus infections were occurring in the country and that the potential effects of the disease could be disastrous. Mrs Ngugi told the workshop that the ministry had made available money to develop an AIDS control programme. She disclosed that a national advisory committee on AIDS to facilitate research and control of the AIDS had been set up. She further said the ministry had produced a policy paper aimed at information guiding and directing health workers on diagnostic management and control of the killer disease. The chief nursing officer said the document outlined a national programme for AIDS. [Text] [Nairobi THE KENYA TIMES in English 4 Apr 86 p 3] /9317

CSO: 5400/110

MALAYSIA

PENANG AUTHORITIES ON HEPATITIS ALERT

Penang THE STAR in English 4 Apr 86 p 3

[Text]

PENANG, Thurs. — Health authorities in Penang have been placed on the alert following an outbreak of hepatitis in the State a week ago.

State Medical and Health Services Director Dr Lim Keow Kheng said that although the disease had not reached epidemic proportions, the authorities were seriously concerned over the rising number of cases.

Twelve people mostly schoolchildren had so far been hit by the infectious virus, she said.

The Medical and Health Services Department was working closely with the State Education Department to check the spread of the disease among schoolchildren.

Dr Lim urged schoolchildren not to frequent stalls or eat unhygienic food.

She said that since the outbreak of the disease, 51 hawkers had been charged in court for health offences and were fined a total of $6,640.

She advised the people against eating cockles and food from unlicensed stalls or drinking water that had not been boiled first. — Bernama

/9274
CSO: 5400/4364

MALAYSIA

MAJOR DENGUE OUTBREAK EXPECTED IN JULY

Penang THE STAR in English 5 Apr 86 p 9

[Text]

KUALA LUMPUR, Fri. — A major outbreak of dengue fever is expected to hit the peninsula probably in July and August, according to a professor.

Prof. S.K. Lam, director of WHO Collaborating Centre for Arbovirus Reference and Research (dengue fever or DF and dengue haemorrhagic fever or DHF), said a study of the disease showed that a major dengue outbreak occurred every four years.

The last major outbreak was in 1982 (where there were 3,006 reported cases with 35 deaths).

Prof. Lam, who is also head of Universiti Malaya's Microbiology Department, said he expected an outbreak based on the following facts:

- MALAYSIA has not experienced a major outbreak of dengue for four years;
- 1985 had the lowest recorded cases of dengue (354 reported dengue cases, 242 of which were DF and 112 DHF and 11 deaths), resembling the low incidence in 1981, the year before the 1982 peak year;
- THE DF/DHF case fatality rates as well as the DF/DHF ratio for 1985 are high, indicating increasing severity of the disease;

(The case fatality rate in 1985 was 9.82 per cent compared to 9.53 in 1975 and 4.07 in 1982).

- THE number of cases reported towards the end of 1985 has been on the increase and several dengue serotypes have been isolated;
- THE concentration of cases in the peninsula, particularly in the more urban and suburban areas of the West Coast; and
- THE increase in the number of houses breeding *aedes aegypti*.

Prof. Lam said in view of the impending outbreak, there was a need for an aggressive campaign to get the public's co-operation to eradicate breeding places of mosquitoes.

He said deaths caused by DHF could be reduced and even eliminated if it was diagnosed early.

SYMPTOMS

He advised those who suffered from symptoms of DF and DHF — sudden fever, severe headache, pain in the muscles, bones and eyeballs, rash and bleeding from the nose, mouth and body — to seek medical treatment immediately.

"The symptoms are sometimes confused with that of influenza and rubella," he said.

Prof. Lam said the role of the WHO Centre was to monitor the situation in the country and to determine dengue sensitive areas.

"This is achieved with the formation of a sentinel network of general practitioners who supply us with clinical specimens of blood from suspect cases," he said.

He added that methods of specimen collection (using filter paper and capillary tubes which are obtainable free of charge from Prof. Lam) and techniques have been developed. They have proved useful in the current outbreak.

At the same time, he said, the Vector Borne Diseases Control Programme under the Health Ministry aimed to break the chain of transmission of dengue and to control the vectors.

"The programme has been most efficient in responding to cases which have been reported. It also conducts *gotong-royong* projects to get rid of old tyres and other containers to prevent the vectors from breeding, and issues summonses and fines," he said.

WORRYING

Although the Health Ministry should be notified of all dengue cases based on clinical signs and symptoms, said Prof. Lam, some doctors were not doing so.

"About 50 per cent of laboratory confirmed cases are not reported to the Ministry while one-third are reported only after confirmation.

"This worrying trend delays the measures that have to be taken to control the vectors. It is better to over-report than under-report in order to break the chain of transmission," he said.

He suggested that the public should be involved and motivated to help eradicate the breeding places of mosquitoes in the areas where they live.

"Organise projects or competitions among schools for greater awareness of the problem," he said.

He added that water should be stored in containers with tight lids and abates, a larvicide, should be used.

/9274
CSO: 5400/4364

BRIEFS

PROGRAM AGAINST GASTROINTESTINAL INFECTIONS--A program aimed at reducing gastro-intestinal infections was announced by Dr Orlando Perez Teran, of the Ministry of Health's Maternal and Infant Department. He revealed that 10 percent of the registered infant deaths are caused by these illnesses. Regional health offices will be created to monitor the epidemiological state of diarrhea and the deaths resulting from it. The doctor also announced that a permanent public education campaign will be intensified and training provided to health workers and empirical healers. There will also be a campaign to promote public hygiene and community cleanup activities. Health units will be on a state of alert, increasing their hours of public service and giving priority to children suffering from these infections. Close to 20,000 cases of gastro-intestinal illnesses are reported each month, but during the rainy season -- May through November -- this total can be as high as 60,000. A decisive factor in this situation, according to Perez Teran, is the low educational level of the population regarding the importance of hygienic measures. Although the Revolution has launched massive health campaigns throughout the country, the underdevelopment inherited from Somoza is still deeply rooted and the war against the country has limited the resources available for health programs. [Text] [Managua BARRICADA INTERNACIONAL in English 27 Mar 86 p 13] /12851

CSO: 5400/2108

NIGERIA

CHOLERA OUTBREAK REPORTED IN ABUJA

Kano THE TRIUMPH in English 12 Mar 86 p 16

[Text] **THE Health Department in the Federal Capital Territory of Abuja, on Monday confirmed an outbreak of Cholera in parts of the territory.**

A statement signed by a Health Superintendent in the department, Alhaji A. Angulu, noted that cholera had been reported in Zuba as well as in the northern and eastern districts of the territory.

The statement added that the cause of the outbreak had been identified as poor and contaminated drinking water in the affected areas.

Already in Zuba, eight persons had died while 68 others had been referred to Gwagwalada for proper treatment.

The principal medical officer who confirmed the deaths advised all inhabitants of the affected areas to boil all drinking water and to properly wash their hands before eating and after using the toilet.

Meanwhile, the health department is currently involved in efforts to check further spread of cholera in Abuja.

In another development, the capital territory has for the past three days been hit by acute scarcity of water.

A correspondent of the News Agency of Nigeria (NAN) reports that inhabitants of the city roam endlessly in search of water since there are no streams from where they could fetch water.

A reliable source told NAN that the engine at Jabi dam, the only source of water to the city, had broken down.

/13104
CSO: 5400/109

NIGERIA

BRIEFS

MOSQUITOES LINKED TO MOUTH CANCER--Some viruses of certain types of mosquitoes have been identified as the major cause of deadly cancer-of-the mouth disease. The disease known as bockett lymphoma in medical circles is a major swelling on the gum of the teeth due to infection and disfigures the face. It is a disease of the tropics and is responsible for most of the facial deformities in children between the ages of two and ten. It sometimes lead to their death. These facts were disclosed exclusively to Sunday Times by Professor J.O. Akinosi - Head of the Department of Oral Surgery at the University of Lagos College of Medicine. [Text] [Lagos SUNDAY TIMES in English 16 Mar 86 p 1] [Article by Dupe Adesioye and Ndubuisi Okwechime] /13104

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PAKISTAN

SURVEY TERMS HEALTH COVERAGE 'INADEQUATE'

Karachi DAWN (Business Supplement) in English 12 Apr 86 pp I, IV

[Article by Zubeida Mustafa]

[Text]

THE PICTURE of the health sector as it emerges from the Federal Bureau of Statistics recently released report bodes ill for the country's economic and social development.

This sector has traditionally been one of the most neglected ones although the state of the people's health has a direct bearing on productivity, economic development and the cost of providing medical cover.

It is patent that the output of a sickly population is low as compared with that of a healthy people — more man-hours are lost because of illness, more people are required to maintain a given level of production and the expendiutre on providing medical cover to the labour force is higher.

The implications of poor health for the social development and the quality of life of a people cannot be discounted either.

The "National Health Survey 1982-83" brings sharply into focus these aspects — that is if one cares to read into the meanings of the statistical tables spread over 158 pages. Since a similar survey on this scale — 11,000 households were covered — has not been conducted before in Pakistan, a comparative assessment is not possible.

It cannot be ascertained if the state of health of the people has improved over the years. The decline in crude death rate does not necessarily imply a lowering in the incidence of disease.

The most important factor to be taken note of is the prevalence of illness among the people. According to WHO, "Health is a state of complete physical, mental and socail well-being and not merely the absence of disease or infirmity."

Deviations from this ideal may be regarded as morbid conditions. They range from minor indisposition causing little intereference with normal activity to the clear-cut case of serious disability.

Accirdubg to the Survey, 17 per cent of the population had suffered from some form of illness during one month prior to the interview. (To minimise the element of variations caused by seasons, the survey was staggered over four quarters). Significantly, morbidity was found to be higher in the rural areas, 18.2 per cent as against 14.3 per cent in the urban centres.

The inadequacy of health cover and poor living conditions in the countryside explain the greater prevalence of illness there. As a result, those sectors of the economy which are rural based, such as agriculture, are more adversely affected by the poor state of health of the people.

One aspect to be noted is the morbidity rate in different age groups. The incidence of illness is higher in people above 50 years of age and in children under four years. What is disturbing from the point of view of the productivity of the labour force is the pattern of morbidity. Good health appears to pick up at the age of 10. But in another 10 years the downward trend begins.

The morbidity rate shows a constant rise from the age of 20 onwards. In fact by the age of 40 it exceeds the national average. It is 19 per cent for the 40-44 years age group and goes up to 29.6 per cent in the 60-64 years bracket — the oldest segment of the labour force. In other words, the health of the labour force peaks out at the age of 20.

Another related factor is the morbidity rate among different professions. Illness is most prevalent in the agricultural and animal husbandry workers — 173.1 per 1000 employed persons. This, of course, is not a very satisfactory state of affairs for a country whose economy depends heavily on agriculture.

Priorities

The healthiest appear to be the clerical workers with a morbidity rate of 94.8 per 1000. The other occupations listed are sales workers 162, service workers 155, professional workers 151, production workers 137 and administrative workers 111 per 1000.

It also emerges clearly from the health survey that the lack of planning and misplaced priorities in the social sectors are making medical facilties inaccessible to the people. It is no occasion for self-congratulation for the health planners if the crude death rate has declined and life expectancy has gone up over the years. Simply sustaining life should not be the objective of the government's health policy. The physical and mental well-being of people is equally important.

The high morbidity rate points to the failure of the government to create conditions conducive to healthy living. Two findings of the survey are significant in this context. First, the disease which has the highest incidence is shown to be malaria and other non-specified fevers—41 per cent of all illnesses.

But it hardly needs to be pointed out that effective community health programmes, especially those directed towards promoting public hygiene and preventive medicine, can easily cut down the prevalence of these illnesses.

Secondly, the survey confirms that housing conditions have a direct bearing on the health of the population. People living in "pucca" houses and having access to piped water, gas/biogas/electricity and with flush toilets in their homes are less prone to illnesses than those who live in kuchcha dwellings, obtain water from wells and pumps, use cow dung and wood as fuel and who use closed pits or open spaces for disposal of waste.

The morbidity rates are quite revealing: pucca houses 155/1000 and others 177/1000, piped water 155/1000, wells 178/1000, and others 161/1000, gas, etc. 135/1000, cow dung, wood, etc. 161/1000 and oil 176/1000, flush toilet 142/1000, without flush 146/1000 and closed pit 183/1000.

Given the government's failure to provide adequate housing, potable water and fuel to the majority of the people, the poor state of health of the people is not unexpected.

Facilities

The FBS survey also underlines, in no uncertain terms, the lack of mass-orientation in the health policy. The paucity of government institutions and the high cost of medicare are clearly established.

While only 15 per cent of the people visited government hospitals, dispensaries and health centres, 42 per cent want to private hospitals/clinics 12 per cent to hakims, one per cent to homoeopaths and 15 per cent to compounders. Five per cent took self-medication and three per cent underwent no treatment at all when ill.

Even in the rural areas where private clinics are relatively scarce, 36 per cent went there. Only 16 per cent visited government institutions. The hakims and compounders saw 14 and 17 per cent of the ill people in the rural areas.

This pattern of treatment is explained by the distribution of the medical institutions in rural areas. Only one per cent of the villages surveyed were less than a kilometre from a public hospital and 69 per cent were more than 10 kilometres away.

The rural health centres and the basic health units are also not as widely dispersed as they should have been, the survey reveals. Only 11 per cent of the sample villages were within one kilometre radius of an RHC and 21 per cent villages from a BHU. Thirty-five per cent and 24 per cent are more than 10 kilometres away from an RHC and BHU respectively. But 28 per cent of the sample areas were within one kilometre radius of a private clinic and only 25 per cent were more than 10 kilometres away.

Inequities

This has logically pushed up the cost of treatment. According to the survey a family with a monthly income of less than Rs 300 was spending Rs 17 on health care. A household earning more than Rs 2500 per month spent Rs 168 on treatment. This points to the inequity which has resulted from the government's failure to provide low cost health care to the population.

This inequity is even more pronounced between the rural and urban areas. The lowest income group spent Rs 18 on health, in the villages as compared with Rs 13 in the cities while the medical expenditure of a household in the most affluent group in the rural areas was Rs 211 as against Rs 149 in the urban areas.

Disparities between the provinces are also glaring. Sind is the most expensive province in terms of medicare whereas Baluchistan is the cheapest. It is clear that the growing dependence on the private sector has contributed to these inequities.

/9317
CSO: 5400/4705

PAKISTAN

QUACKERY DESCRIBED, SAID WELL INSTITUTED IN SOCIETY

Karachi DAWN Magazine in English 11 Apr 86 pp I, IV

[Article by Nafisa Hoodbhoy]

[Text]

We found the quack sitting in his clinic. A middle-aged respectable looking man, he rose and invited us in graciously when the doctor with me pretended to be a patient. "Doctor, I have a cough and get phlegm in the mornings," he sputtered to the quack, who proceeded to unbutton his shirt and listen intently with a stethescope.

In a few minutes, the quack had written the prescription and handed over the remedy: tetracyclin (an anti-biotic with sideeffects such as the permanent staining of teeth, lowering of defence mechanisms and allergic reactions) and home-made Benadryl — a mixture of sherbet and water.

The "doctor" then advised the "patient" to drink cold water and avoid rice. He asked for Rs 20 as fee, settling for Rs 10 when the real doctor said he didn't have that much of money.

The team of three doctors and myself who set out quack hunting found the menace most prevalent in the low-income areas of Karachi — where poverty and ignorance are rife.

Driving on the dirt roads, we passed quack clinics with Dr so and so on the name plates — but without an MBBS after the names. A "doctor" had "Med. Pract." written after his name. Another had, however, gone all the way to mention his medical degrees, including a Professional and Linguistic Assessment Board (PLAB) entrance examination! (The test is merely on English language and asks some questions on the profession).

In Lyari, we stopped to see a quack who had been running a clinic for over six years and was distantly known to a member of our team. He was a dark, bulky man getting on in his 40's. The doctors with me identified themselves. Instinctively, the quack was on the defensive.

On our query he said he saw 50 to 70 patients per day, charging Rs seven from adults and Rs five from children.

"But all the income is spent on buying medicines," he said with a sigh. (We pretended we had not noticed that his cupboards were lined with free drug-samples from pharmaceutical companies).

There was an embarrassing silence when I asked the quack, "Where did you graduate from?" He leaned back, his protruding belly almost touching the desk.

"Chandka Medical College," he replied.

(The CMC had begun graduating its first batch only for the last few years. Our host meanwhile had been practising for well over six years).

Going through the narrow crooked lanes of New Karachi, Mahmoodabad, Drigh Colony, Kumharwala and Orangi, one was reminded of the old nursery rhyme. "Here a quack, there a quack, everywhere a quack quack." Like 'paan' shops, the quack clinics had opened in single rooms, devoid of the barest of clinical facilities.

Investment

A few thousand rupees down payment, a few hundred rupees rent to set up a clinic, and the quack worked hard to recover his investment. In several cases he had the added advantage of inheriting the family clinic, thereby adding to his accumulated wealth.

We came across an established quack, whose clinic had been running for the last 35 years. He was a courteous elderly man with 'Pan'-stained teeth. He had been dispensing allopathic medicines for dysentry, asthma and TB.

The quack told the doctors with me that for TB he gave steptomycin and INH (the former if unmonitored leads to stone deafness, the latter to a numbness of hands and feet). For asthma he prescribed steroids (sideeffects: destruction of the immune system, diabetes and possible hypertension).

He had, however, done well for himself. He lived in a bungalow a 200 home and had sons who were gainfully employed or getting education.

The quack looked a well-meaning person who had worked hard to raise standards for his family. Our target was not to single out individuals. Just looking around one realised that the institution of quackery has taken such root in our society that it would not be solved by the police tearing down a few quack clinics.

Instead, doctors need to organize themselves, the way the quacks have organized to defend their interests. A case in point is the procession quacks recently took out in New Karachi against a newcomer doctor after his patient died. (The doctor claimed he was not to blame because the patient was not removed to hospital despite his instructions). However, the quacks continued to harass him until he was forced to close down his clinic in the area.

Another example of quack unity showed itself in the case of a lady doctor who left her new clinic in Lyari to go abroad for a fortnight. In her absence, the area's quacks told patients she had left for good. Upon her return, the doctor found that female patients had shifted their maternity bookings. Finding difficulty in restarting the clinic, the lady doctor closed the clinic.

However, the obstacles to doctors may just have begun. Working on the same lines as their aggressive counterparts in the Punjab, quacks in Sind are trying to get themselves registered as medical practitioners. By collecting individual donations, the quacks want to form a trade union, which will enable them to practise openly in the province.

Some quacks have adopted other methods. Their children are studying in medical colleges and will in the future run the clinics they inherit. Still others have hired qualified doctors, nurses and technicians to work in their clinics, while they actually run the show.

We visited a clinic of that nature in Mohajir Colony. Who owned the clinic was a moot point. However, a quack (employee of a government hospital) ran the clinic most of the time since the doctor (a former high official of a government hospital) and his wife came only briefly.

Desolation

In the dusty barren surroundings of Mohajir Colony, the clinic looked a picture of desolation. It was not doing well, judging from the fact that it was closed at 4 p.m. No doctor or nurse was willing to work in such out of the way facilities, we found out.

This unwillingness of qualified medical personnel to work in remote areas of Karachi has created a vacuum — filled by quacks. Doctors argue that it is pointless for them to serve in localities where even the barest of clinical facilities are not available. Quacks have no such problem. All they need is a table with a few bottles of sherbet and bright capsules.

Interestingly, some of the lower staff of government hospitals who have picked up the ABC of medicine are running successful quack clinics. Often, residing in the areas they serve, they are practising quackery in Mohajir Colony, Azizabad, Lalukhet, Landhi, Kharadar and Gulshan-i-Iqbal ... to name only a few.

One of the most successful quacks employed in a government hospital runs two full-time clinics and owns two cars — one a recent model. He makes an occasional appearance at his government job to "share a cigarette" and buy medicines for his clinics.

In the long run, however, there are no winners in this game of quackery. The quack, himself a product of poverty and ignorance, is forced to depend on qualified medical care for himself and his families. Or, when a case has been spoiled by a quack, the patiennt is brought to the doctor.

One doctor in a government hospital recalls removing "sixteen maggots of worms" caused by wound infection of a child circumcised in Malir. Doctors here testified to the anatomical damage done when a quack uses "butcher-like techniques" in cutting off the umbilical cord — leading to hernia or in the case of females other complications.

Predictably, the patient's complications arise because the quack does not investigate the disease and uses a blanket method of treating the symptoms.

For instance, a patient suffering from jaundice was recently given a diazepam injection by a quack to treat his symptoms of restlessness. Not only did the injection calm the patient, it put him in hepatic coma for a day. He died within 48 hours of admission to a hospital.

Furthermore, the use of steroids by quacks to treat fever, asthama or TB has a range of negative sideeffects. Firstly, the patient develops resistance to the disease. He may also develop secondary diseases like hypertension, diabetes or bone disorder. Having started out with one disease and ending up with another further prevents him from squarely blaming the quack.

Not only that. The patient's own ignorance frequently leads him to demand what doctors describe as "wonder drugs." A mini-bus driver suffering from high fever who has to drive his mini early in the morning does not want to wait until a doctor tests a drug on him. He turns to the quack for an anti-pyretic injection which kills the fever in an hour. Next day, however, the driver goes around with numb sensations

in hands and feet and loses concentration with possible damage to the brain.

If quackery is in effect playing with the lives of the people, why is it flourishing? Multinational pharmaceutical companies and their representatives continue to give free drug samples to quacks, who in turn liberally promote their products. Doctors on the other hand, are more cautious in promoting drugs whose efficacy is not known.

Surely, no government can allow the nation's health to be jeopardised, especially a government which had only a few years ago promulgated an anti-quackery Ordinance. Adding insult to injury, however, a high level health official recently went out of his way to patronise quackery. He inaugurated a Cancer Clinic in Hyderabad, which claims to have found a cure for canncer — which has still not been found in the rest of the world!

The examples I had seen to quackery thriving in remote areas of Karachi can be multiplied several times in the rural areas, where it has become a way of life.

Doctors say, rightly, that if they are asked to serve in pre-historic conditions, without electricity, water or the most minimal facilities, their services become meaningless. The result: quackery flourishes and people perish.

The Pakistan Medical Association, which broadly represents the medical profession, has been consistently urging the government to expand health facilities in the rural areas in order to absorb the "surplus" of qualified doctors and provide the much needed health care to the masses.

At the national level, the PMA and junior doctors' groups have been calling for the enforcement of the anti-quackery ordinance. (An anti-quackery committee formed by PMA, Karachi is still only on paper). They have urged doctors with established clinics to join in the struggle against quackery.

So deep rooted, however, is the menace of quacker that it will not be eradicated without a fundamental shake-up of the health delivery system. It is imperative, though, that the nation be educated about this slow poison.

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CSO: 5400/4705

PAPUA NEW GUINEA

CONJUNCTIVITIS EPIDEMIC REPORTED IN PORT MORESBY

Port Moresby PAPUA NEW GUINEA POST COURIER in English 7 Apr 86 p 1

[Article by Timothy Kwara]

[Text] AN AVERAGE of 10 people are being treated each day in Port Moresby clinics for sore eyes.

The disease known as conjunctivitis is caused by a virus.

Dr Mari Apana, who owns a private clinic in Taurama, said: "It is an epidemic."

But it was difficult to find the cause.

He warned that those affected should stay at home and not walk around in the rain.

Another clinic doctor, Dr Pangatana, said the germs could only be seen by an electronic microscope.

Severe cases could last for two to three weeks while moderate ones could take a week to heal. Mild ones could last for a few days.

Dr Pangatana said 90 per cent of his patients came from the city, the rest came from nearby villages.

"Just like the common cold, the virus causing the infection cannot be stopped," he said.

Another doctor warned people to wash their hands carefully because the disease could be spread by contact. The virus was also believed to be air-borne.

Dr Glen Mola said the only way to prevent the disease was by those affected staying at home.

The symptoms are red, swollen and itchy eyes — as Post-Courier journalist Soldier Buruka experienced last Friday.

"I had sharp pain and tears in my eyes but I drank Aspro which eased the pain," he said.

Many people were also affected by the disease in his village, Tubusereia, Central Province.

/12851
CSO: 5400/4363

PEOPLE'S DEMOCRATIC REPUBLIC OF YEMEN

BRIEFS

CHOLERA, TYPHUS-FREE AREA--An official at the Ministry of Public Health today announced that the PDRY is free of cholera and typhus. This has been established by a field survey, including clinical and laboratory tests, which was carried out by a Health Ministry committee charged with the task following the recent events in the country. No cases have been observed. [Summary] [Aden Domestic Service in Arabic 1500 GMT 15 Mar 86 GF]

/12929
CSO: 5400/512

SWAZILAND

BRIEFS

WARNING AGAINST AIDS--Swazis traveling abroad have been advised to take their own towels and soap, and not use those supplied in hotels because of the danger of AIDS. The warning came on Thursday from Minister of Health Prince Phiwokwakhe, while answering questions in Parliament about the disease. The Minister said that so far no cases of the disease had been reported in the kindgom, but he said cases had been reported in neighbouring countries. He also said that homosexuality, which seemed to be associated with the spread of the disease, was on the increase in Swaziland.--Sapa [Text] [Johannesburg THE STAR in English 29 Mar 86 p 4] /9317

CSO: 5400/111

TANZANIA

BRIEFS

CHOLERA OUTBREAK IN MARA--Musoma: Eleven residents of Butiama Village, Musoma Rural District, Mara Region, have died of cholera. The assistant medical officer of health at Butiama Health Center, Ndugu Alfred Warioba, has said the dead were among 35 people who contracted the disease since 18 March. Twenty-four patients--4 men and 20 women--were admitted to the health center for treatment. The Mara regional commissioner, Ndugu Augustine Mwingira, has said that a group of doctors and medical personnel from the regional hospital and others from the Shirati Mission Hospital are in the village to fight the disease. [Text] [Dar es Salaam Domestic Service in Swahili 1000 GMT 23 Mar 86 EA] /9599

CSO: 3400/1421

'MAJOR OUTBREAK' OF RABIES REPORTED IN ONTARIO COUNTY

Toronto THE GLOBE AND MAIL in English 1 Apr 86 p A17

[Article by Mark Bourrie]

[Text]

MIDLAND, Ont.

Simcoe County, which has one of the highest rates of rabies in the world, is in the midst of a major outbreak in which dozens of pets have been exposed and rabid wild animals found near homes.

Joel Rumney, a farm veterinarian who practices in three rural townships north of Barrie, said the outbreak is the worst he has seen.

Dr. Rumney said he has destroyed an average of 12 animals each week for several months because they had been exposed to the disease. During the winter, he was called to a farmhouse by a family that had trapped a rabid fox in their living room.

"The chap, who had a heart condition, went to let his dog into the house. The fox was right on his tail. The dog got back out of the house, but the fox kept on going. They called me, and I came and shot it right in their living room. It smelled of skunk and had a face full of porcupine quills," Dr. Rumney said.

Willard Shantz, regional veterinarian for the federal Department of Agriculture, said in an interview that 12 people living in the village of New Lowell, near Barrie, were given anti-rabies shots during the winter after being exposed to a rabid dog.

Rabid foxes have also been found inside Barrie city limits.

Dr. Rumney said rabies has been found in foxes, skunks and, for the first time in many years, raccoons. Pets and farm animals have also been infected.

Last Friday, Dr. Rumney was exposed to a rabid cow and he said he is undergoing tests for the disease.

"It's simplistic to say that all the foxes should be shot. Normally, foxes aren't pests and have an important role to play in the wild. Instead of providing money for research, the provincial Government keeps trying to hush the problem up.

"I see it as a misappropriation of funds for the Ministry of Natural Resources to spend $100,000 to put radio collars on deer, which are plentiful to the point of being a nuisance, to study their population, while not spending more on (rabies) research.

"I don't know what it's going to take for the Ministry of Natural Resources to get involved. Maybe someone is going to have to die, or there has to be a big lawsuit before they become concerned enough to funnel money into research."

Dr. Rumney suggested that municipal councils consider enacting legislation under a new provincial law that allows municipalities to pass bylaws ordering all pets to be vaccinated.

"People come into my office and say their animals never get near wild animals, but a study showed 10 per cent of the bats in this area are rabid. Cats catch bats. And, the case with the fox in the people's house shows that even a dog that stays near the house isn't safe," Dr. Rumney said.

/9317
CSO: 5420/67

RINDERPEST EPIDEMIC SPREADS FROM BIHAR TO WEST BENGAL

Calcutta THE TELEGRAPH in English 21 Mar 86 p 6

[Article by Uttam Sengupta]

[Text] Ranchi, March 20: The rinderpest epidemic has spread from the industrial centres of Bihar to West Bengal. While the casualty figure in Bihar is close to 5,000, more than 500 heads of cattle have already died in West Bengal.

Veterinary surgeons here have said there is no cure for the disease and the treatment could only be symptomatic. Mostly high-yielding cows and buffaloes have succumbed to the disease. Since each of these costs on an average around Rs 15,000, the loss in Ranchi alone is estimated to be well over Rs 1 crore.

Nearly 700 heads of cattle have died in Ranchi so far. Other badly-affected areas are Bokaro and Jamshedpur.

Official sources in the animal husbandry department said the Centre had formulated a national rinderpest eradication programme in 1954 and the disease had been totally controlled by the mid-Sixties. This year, however, the epidemic had been totally devastating.

The recent outbreak of the disease was almost certainly due to the smuggling of cattle from across the borders, the sources claimed. Moreover, many cattle-owners refused to use rinderpest vaccines, preferring to hold *yagnas* instead. They have been the hardest hit, the sources said.

Disposal of the rotting carcasses is another problem facing the Ranchi Municipal Corporation. Corporation workers are being prevented from burying the carcasses in the outskirts of the city by the villagers. They are also unable to find persons willing to perform the task.

Some of the dead cattle have been buried in the children's park opposite the headquarters of the Central Coalfields here. The stench, however, continues to pervade the area, indicating that the burial has not been done properly.

/12851
CSO: 5450/0129

ST VINCENT AND THE GRENADINES

BRIEFS

FRUIT FLY STUDY--The Fruit Fly Survey Programme which is being conducted by the Ministry of Trade and Agriculture has been implemented and is progressing satisfactorily. Last week, the trappers were engaged in putting out the McPhail Traps, mainly around the Kingstown area. The trapping will soon be extended to other areas. Thus far, traps put out were serviced and classification of insects made by the Entomologist, Amy Dreves, indicated that no fruit flies have yet been identified. The programme will last for eighteen (18) months after which time, if no fruit flies are present, St Vincent and the Grenadines will achieve a "Pest Free Status" where fruit flies are concerned. This would allow for the exportation of fruits to the United States. The general public has been asked to give full cooperation to allow the smooth running of the programme. [Text] [Kingstown THE VINCENTIAN in English 28 Feb 86 p A] /12851

CSO: 5440/070

MEALYBUG OUTBREAK IN SAMFYA DESTROYS CASSAVA, CAUSES FAMINE

Lusaka TIMES OF ZAMBIA in English 15 Mar 86 p 1

[Text] SAMFYA district has been hit by famine following the outbreak of mealybug pest which has destroyed cassava — the staple food there.

The pest is threatening other parts of Zambia including parts of Northern, Central and Copperbelt provinces.

Already, tracks of cassava fields in Mwense in Luapula have been wiped out although the worst affected was Samfya.

Luapula provincial agricultural officer Mr Jason Sinkamba confirmed this in Mansa yesterday and said the bug crossed into Zambia at Mwense more than six years ago, but it had now spread to Kaputa and Mporokoso in the Northern Province; Serenje in Central and most border towns on the Copperbelt.

Mr Sinkamba said since January, people in Samfya relied on food relief from Government because their fields had been destroyed by the bug.

He blamed the people for ignoring a Government ban on the movement of stems and tubers for the widespread of the pest.

The bug was first spotted at Mwense in 1980 and immediately authorities instituted measures to control its spread through education drive by extension personnel.

But in 1984, the disease had virtually affected most parts of the province when a Mount Makulu Research Station team moved in.

"By then many cassava fields were already devastated beyond control. The situation was more severe in Samfya as it is now".

Mr Sinkamba said with the help of the International Insititute of Tropical Agriculture in Ibadan, Nigeria, who were breeding parasite resistant cultivars (insects) which attacked the bugs, the situation was expected to be brought under control.

So far cultivars were being experimented on two fields in Mansa and Mwense and results had proved very encouraging.

"We have now requested for more of these insects. But for the moment people should avoid moving cassava plants from one area to another".

He said even when the cultivars were introduced from Nigeria or Mt Makulu, it would take many years to repair the damage.

Thirty countries in Africa have been afflicted by the deadly disease. In Zambia, it threatens many people in Luapula, Central and Copperbelt where cassava was staple or partially staple food.

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CSO: 5400/112

END